U.S. Department of Labor

Office of Administrative Law Judges
36 E. 7th St., Suite 2525
Cincinnati, Ohio 45202

(513) 684-3252
(513) 684-6108 (FAX)

Issue Date: 28 August 2007

Case No.: 2006-BLA-00001

In the Matter of:

L.S. (Widow) of
F.S. (Deceased),[1]
Claimant,

v.

MIDWEST COAL CO., INC.,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

L.S., *Pro se*

Richard H. Risse, Esq.
For the employer

BEFORE: DONALD W. MOSSER
Administrative Law Judge

DECISION AND ORDER – DENYING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (the "Act"). In a case involving a living coal miner, benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2005).

[1] In any Decision and Order issued by the U.S. Department of Labor in Black Lung cases after August 1, 2006, the claimant is referred to only by initials rather than by full name in the interest of protecting their privacy.

Following proper notice to all parties, a hearing was held on November 13, 2006 in Terre Haute, Indiana. The parties were given the opportunity to submit evidence at the hearing, and submit post-hearing briefs.[2] The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. The appraisal of the medical evidence has been conducted in conformity with the quality standards of the regulations. The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title.

ISSUES

The following issues remain for resolution:

1. whether the evidence establishes a change in conditions or a mistake in a determination of fact within the meaning of Section 725.310;

2. whether the miner had pneumoconiosis as defined by the Act and regulations;

3. whether his pneumoconiosis arose out of coal mine employment; and,

4. whether the miner's disability was due to pneumoconiosis.

(Tr. 7; DX 93).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

The miner filed his initial claim for black lung benefits on January 30, 1984. (DX 23). This claim was denied by the district director on the grounds that the miner failed to show he suffered from pneumoconiosis or that he was totally disabled. (DX 23). On November 22, 1991, the miner filed a subsequent claim for benefits. (DX 1). This claim was denied on April 30, 1996 by an administrative law judge on the grounds that the miner could not show the existence of pneumoconiosis. No other elements of entitlement were considered. (DX 47).

On March 27, 1997, the miner filed a request for modification of the April 30, 1996 decision. (DX 48). After a formal hearing, this claim was again denied by an administrative law judge on January 11, 2002. The administrative law judge found that the miner had not

[2] References in this decision to DX pertain to the exhibits of the Director. References to CX and EX pertain to the new exhibits of the claimant and employer filed in connection with the current request for modification. References to O-CX and O-EX refer to the old exhibits of the claimant and employer filed in connection with the previous requests for modification.

established the existence of pneumoconiosis and therefore could not prove an issue of entitlement that was previously decided against him. (DX 74). This decision was later affirmed by the Benefits Review Board on January 10, 2003. (DX 75).

The miner filed another claim for benefits on October 10, 2003. (DX 78). By letter dated October 27, 2003, the district director informed the miner that this claim would be treated as a request for modification since it was filed less that one year after the previous final denial. (DX 83). A formal hearing was held on October 25, 2005. The miner died on November 27, 2005, before the administrative law judge could issue a decision and order. The claim was then remanded to the district director in order for the claimant, the deceased miner's wife, to submit an autopsy and develop additional medical evidence. (DX 94). After receiving the additional medical evidence, the claim was once again referred to the Office of Administrative Law Judges for a formal hearing, which I conducted in 2006.

Claimant testified at the October 25, 2005 hearing on the miner's behalf. She stated that she and the miner were married in 1978. (Tr. 21). The couple lived together in the same household while the miner worked in the coal mine industry. (Tr. 22). Claimant estimated that the miner smoked as much as a pack and a half of cigarettes per day for twenty or thirty years before quitting in 1978. (Tr. 28). She further testified that the miner's breathing problems became "really bad" in the last ten years. (Tr. 25). In the claimant's opinion, her husband was not able to perform his previous coal mining position due to his breathing problems. (Tr. 28).

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. The district director found and the employer stipulated that the miner worked at least eighteen years in coal mine employment. (Tr. 6). Based upon my review of the record, I accept the findings of the district director as accurate and credit the miner with at least eighteen years of coal mine employment.

Claimant testified that the miner quit his coal mine employment sometime "in the '80s." (Tr. 22). He worked as a pan and dozer operator, a truck driver, and as a driller. (Tr. 23). According to the claimant, approximately two years of the miner's employment was underground, and sixteen years were above ground. (Tr. 23). The miner's last full year of coal mine employment was at the tipple, shoveling coal in dusty conditions. (Tr. 23).

Modification of a Duplicate Claim

Section 725.310 provides that a claimant may file a petition for modification within one year of the last denial of benefits. Modification petitions may be based upon a change in condition or a mistake in a determination of fact. 20 C.F.R. § 725.310(a). An award in a black lung claim may be modified (increased, decreased, or terminated) at the behest of the claimant, employer, or district director upon demonstrating either that (1) a "change in conditions" has occurred, or (2) there was a "mistake in a determination of fact." 20 C.F.R. §725.310 (2000) and (2001); *King v. Jericol Mining, Inc.*, 246 F.3d 822 (6th Cir. 2001) (modification available to employers as well as claimants).

In determining whether a "change in conditions" is established, the fact-finder must conduct an independent assessment of the newly submitted evidence (all evidence submitted subsequent to the prior denial) and consider it in conjunction with the previously submitted evidence to determine if the weight of the new evidence is sufficient to demonstrate an element or elements of entitlement previously adjudicated against claimant. *Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994); *Napier v. Director, OWCP*, 17 B.L.R. 1-111 (1993); *Nataloni v. Director, OWCP*, 17 B.L.R. 1-82 (1993). The circuit courts and Benefits Review Board have held that, for purposes of establishing modification, the phrase "change in conditions" refers to a change in the claimant's physical condition. *See General Dynamics Corp. v. Director, OWCP*, 673 F.2d 23 (1st Cir. 1982); *Director, OWCP v. Drummond Coal Co.*, 831 F.2d 240 (11th Cir. 1987); *Lukman v. Director, OWCP*, 11 B.L.R. 1-71 (1988) (*Lukman II*).

Even if a "change in conditions" is not established, evidence in the entire claim file must be considered to determine whether a "mistake in a determination of fact" was made. This is required even where no specific mistake of fact has been alleged. *Worrell, supra; Jessee, supra; Kingery, supra; Kovac, supra*. The Seventh Circuit Court of Appeals has noted that the reopening provision is to be interpreted generously to the claimant. *Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992). *See also O'Keefe v. Aerojet-General Shipyards Inc.*, 404 U.S. 254, 256 (1971). Under *Franklin*, "mistake in a determination of fact" includes mixed questions of law and fact, including the "ultimate fact" of whether the claimant is entitled to benefits under the Act. *Id.* at 358.

I reiterate that the claimant has again requested modification of the denial of the claim filed by the miner in 1991. That claim was a duplicate claim; therefore, in order to be entitled to benefits, claimant must also establish a material change in conditions since the previous claim was denied. 20 C.F.R. § 725.309(d). I must consider the new evidence and determine whether claimant has proved at least one of the elements of entitlement previously decided against the miner. If so, then I must consider whether all of the evidence establishes that the miner's claim should be approved and benefits awarded. *Hess v. Director, OWCP*, 21 BLR 1-141, 1-143 (1998).

In the prior denial, the Benefits Review Board affirmed the administrative law judge's decision that claimant failed to show he suffered from pneumoconiosis, although he did prove with new evidence that he was totally disabled. Based upon my review of the record as it existed at the time of this decision, I find no mistake of fact, even of the ultimate fact. The evidence submitted since this decision includes hospital records, examination reports, pulmonary function studies, and arterial blood gas studies. Therefore, I will consider whether this evidence, in conjunction with the previously submitted evidence, establishes a change in conditions to entitle the claimant to benefits. I will also consider whether the claimant had proved at least one of the elements of entitlement previously decided against the miner.

Pneumoconiosis and Related Issues

Medical Evidence

X-Ray Reports

In connection with the current request for modification filed in October of 2003, the following chest x-ray interpretations were submitted:

Exhibit	Date of X-ray	Physician/Qualifications	Interpretation
EX 1	03/08/04	L.H. Repsher/B-reader	0/0
EX 1	03/08/04	T.E. Schulthesis/BCR	Pleural and cardiomegaly.
EX 2	03/08/04	J.F. Wiot/B-reader, Board-certified radiologist	No evidence of pneumoconiosis
EX 4	03/08/04	J.J. Renn/B-reader	No evidence of pneumoconiosis

The record in the miner's previous request for modification filed March 27, 1997 contains thirty-three x-ray interpretations.[3] Of these, only ten were read as positive for pneumoconiosis. A detailed summary of these chest x-ray interpretations can be found in the previous denial by the administrative law judge dated January 11, 2002. (DX 74).

Pulmonary Function Studies

The following pulmonary function studies were submitted in connection with the current request for modification:

Exhibit/ Date	Physician	Age/ Height	Broncho-dilator?	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
O-CX 1/ 01/20/04	R.A. Cohen	71/ 67"	No Yes	1.17 1.31	1.82 1.93	71 N/A	64% 68%	Yes Yes	Very good comprehension and cooperation

[3] The current claim is a request for modification of the claim initially filed in 1991. Claimant also filed a previous claim in 1984. (DX 23). The medical evidence in both these claims date prior to 1993. The Board has held that it is proper to afford the results of recent medical testing more weight over earlier testing. *See Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (granting greater weight to a more recent x-ray); *Coleman v. Ramey Coal Co.*, 18 B.L.R. 1-17 (1993) (granting greater weight to a more recent pulmonary function study); *Schretroma v. Director, OWCP*, 18 B.L.R. (1993) (granting greater weight to a more recent arterial blood gas analysis); *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985) (granting greater weight to a more recent medical report). As the medical evidence in the miner's previous claims is over ten years old, I grant greater weight to the newer evidence. Accordingly, I continue to rely on the more recent evidence in making my decision regarding the current request for modification. To the extent that the medical evidence submitted prior to 1993 is summarized in prior administrative law judge decisions of record, those summaries are incorporated herein.

Exhibit/ Date	Physician	Age/ Height	Broncho-dilator?	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
EX 1/	L.H.	71/	No	0.81	1.34	N/A	60%	Yes	N/A
03/08/04	Repsher	67"	Yes	0.90	1.35		67%	Yes	

In connection with the 1997 request for modification, the following pulmonary function tests were submitted:

Exhibit/ Date	Physician	Age/ Height	Broncho-dilator?	FEV_1	FVC	MVV	FEV_1 / FVC	Tracings	Comments
DX 52/	Cohen	64/	No	1.33	1.95	60	68%	Yes	N/A
10/15/96		67"	Yes	1.31	1.96		66%		
DX 57/	Selby	65/	No	1.22	1.81	49	67%	Yes	Good effort
08/21/97		67"							

Blood Gas Studies

The following blood gas studies were submitted with the claimant's current request for modification:

Exhibit	Date of Exam	Physician	Resting/ Exercise	pCO_2	pO_2
O-CX 1	01/20/04	R.A. Cohen	Resting	46.2	76.6
EX 1	03/08/04	L.H. Repsher	Resting	52.9	69.0

Two blood gas studies were submitted in the 1997 request for modification:

Exhibit	Date of Exam	Physician	Resting/ Exercise	pCO_2	pO_2
DX 48	10/15/96	Cohen	Resting	42.5	79.1
DX 57	08/21/97	Selby	Resting	44	79

Treatment Records

The employer submitted medical records from Terre Haute Regional Hospital. (EX 5). These records date back to 1982 when the miner was admitted to receive a cardiac catherization. During this visit, the miner was diagnosed with total occlusion of the right coronary artery and significant coronary artery disease. In 1997, he again visited the hospital complaining of chest pain. On this visit, he was diagnosed with chronic obstructive pulmonary disease (COPD), interstitial lung disease, asthmatic bronchitis, arteriosclerotic heart disease, and syncope.

Also submitted by the employer are voluminous medical records from Union Hospital. (EX 6). In 1994, the miner visited the hospital for a cholescintigram. In 1995, he was again admitted complaining of severe shortness of breath, cough, and wheezing. He was diagnosed with acute asthmatic bronchitis, COPD, lung disease due to pneumoconiosis, and arteriosclerotic heart disease. Over the years, he visited Union Hospital on several occasions complaining chiefly of rectal bleeding (1998) and shortness of breath (2000, 2002). In many of the records of these visits, it is noted that the miner had a past medical history of black lung disease. A chest x-ray taken November 6, 2002 showed "increased interstitial opacities" and pleural thickenings. In 2004, he presented to the hospital with complains of severe dizziness, nausea, and vomiting.

The miner again visited Union Hospital on October 12, 2005. (DX 96; EX 13). The majority of the records from this visit are related to the miner's ankle injury and are not relevant to this claim. He was discharged on October 28, 2005 with a diagnosis of severe ankle displace fracture. In the discharge summary, it was noted that the miner had a history of severe interstitial lung disease and chronic obstructive lung disease. (DX 96). Dr. Lawrence Dultz also noted that the miner was "previously diagnosed" with coal workers' pneumoconiosis. He noted that the miner was coughing and raising a "yellow-green sputum." (DX 96; EX 13).

The miner was also admitted into Union Hospital on October 29, 2005. Dr. Dultz performed a pulmonary function study on November 3, 2005, which he opined revealed airways obstruction with incomplete reversibility, consistent with COPD. (DX 96; EX 13). He noted there was severe restrictive lung disease present consistent with an interstitial process, including black lung. (DX 96; EX 13).

The miner visited Union Hospital for a final time on November 19, 2005. (DX 96; EX 13). The records of the visit indicate that the miner first arrived in the Emergency Room complaining of significant abdominal pain. It was noted that the miner had a myocardial infraction a month prior to admission. The miner was found to have an acute abdomen with perforated viscus. He underwent exploratory surgery but his postoperative course was quite complex due to his overall medical condition. After the surgery, he remained on ventilation and his weaning was "quite unsuccessful." Dr. Dultz, after discussion with the family, "made the patient a NO CODE and he was extubated." The miner eventually expired on November 27, 2005.

The miner's treating physician was Dr. Antwan Mardini. His treatment notes indicate that the miner was treated by Dr. Mardini a total of nine times between January of 2004 and October of 2005. The majority of these records are illegible, but it appears that the miner was seen for a variety of illnesses. (EX 11).

Dr. Lawrence Dultz's medical records were also submitted. (EX 12). Included in the records are the results of several portable chest x-rays of the miner taken in November of 2005. He was noted to have a persistent abnormal chest radiograph "without pneumothorax." Pleural effusion was also noted in at least one of these x-rays. The findings in the x-rays were considered "most suggestive of pulmonary edema." (EX 12).

Medical Reports

On January 20, 2004, the miner was examined by Dr. Robert Cohen, who is board-certified in internal medicine and pulmonary disease. (O-CX 1). This physician noted that the miner was a 71-year-old former coal worker with a history of 18 years of coal mine employment. The miner provided a history of "shortness of breath, PND, and orthopnea since 1983 following a myocardial infarction and CABG." Dr. Cohen noted that the miner had a smoking history of one and one-half pack of cigarettes per day for twenty years before quitting in 1973. Upon physical examination, the physician found the miner's lungs to show bilateral wheezes with prolonged expiration. He found the miner's chest x-ray to be negative for pneumoconiosis but positive for pleural disease. He noted the pulmonary function test and arterial blood gas study showed severe restrictive defect. Although he found no evidence of coal worker's pneumoconiosis by x-ray, Dr. Cohen noted that there was physiologic evidence of the disease on his pulmonary function testing. According to Dr. Cohen, the miner's obstructive defect was consistent with his 18 years of coal dust exposure and his 30 pack years of exposure to tobacco smoke. (O-CX 1).

Dr. Lawrence Dultz, the miner's treating physician, provided a medical report dated November 9, 2005. (CX 2). The miner was treated by Dr. Dultz on October 13, 2005, while he was hospitalized for a fractured leg. According to Dr. Dultz, who is a pulmonary specialist, the miner was "known to have chronic lung disease but had not smoked for over 30 years." The physician noted that the miner had been diagnosed with black lung disease "at some point in the past although the details were lacking." During the course of Dr. Dultz's treatment of the miner, a CT scan of his thorax was performed which Dr. Dultz opined showed clear evidence of prior asbestos exposure and basilar ground glass opacities "which could have been consistent with an interstitial process such as black lung." He found the pulmonary function testing performed on November 3, 2005 during the miner's hospitalization showed severe restrictive lung disease. Based on the miner's work history, pulmonary function test results, and radiographic findings, Dr. Dultz felt that the miner had coal workers' pneumoconiosis, "albeit without being classis for black lung in and of itself." (CX 2).

Dr. Antwan Mardini was the miner's primary treating physician at the time of his death. (CX 3). This physician provided a medical report dated November 3, 2005 in which he stated he treated the miner for "several years." According to Dr. Mardini, he treated the miner in his office and in the hospital for chronic shortness of breath. Dr. Mardini opined that this shortness of breath was so severe in nature that it caused the miner to be completely disabled. He further noted that the miner has "multiple chest x-rays and pulmonary function tests" that are compatible with a diagnosis of coal workers' pneumoconiosis after multiple years of employment in the coal mines. (CX 3).

The miner was seen in consultation by Dr. Lawrence Repsher on March 8, 2004. (EX 1). The physician, who is board-certified in internal medicine and pulmonary disease, noted that the miner was a 71-year old male who had worked as a coal miner for eighteen or more years. He added that the miner's last coal mining position was as a triple laborer, which included being a belt man and shoveling spilled coal. During the examination, the miner complained of

progressive dyspnea on exertion and productive cough. He denied any chest pain or hemoptysis, but did complain of severe orthopnea. Dr. Repsher reported a smoking history of one to one and a half packs of cigarettes per day since age eight, quitting in 1973. The physical examination revealed a well-developed, obese male in mile respiratory distress at rest and severe respiratory distress at minimal exertion.

Dr. Repsher opined that the miner's chest x-ray taken during the examination showed no evidence of coal workers' pneumoconiosis and he rated it as category 0/0. (EX 1). The physician also performed a CT scan which showed probable post inflammatory pleural plaques and some areas of calcification of the left diffuse plaque. He noted that the pulmonary function tests he performed were uninterpretable due to the miner's poor effort and cooperation, although he also opined that the "shape of the expiratory loop would suggest some degree of airways obstruction." (EX 1). Overall, Dr. Repsher opined that the miner showed no evidence of coal workers' pneumoconiosis or any pulmonary or respiratory condition caused or aggravated by coal mine employment. He based this opinion on the chest x-ray evidence, pulmonary function evidence, and arterial blood gas studies. He noted that the miner suffered from coronary artery disease, chronic acid peptic disease, GERD, osteoarthritis, obesity, and chemical diabetes mellitus. In the physician's opinion, the miner was probably disabled from his usual coal mine work. However, according to Dr. Repsher, this disability was "overwhelmingly most likely due to his underlying severe coronary artery disease with some possible contribution from cigarette smoking induced COPD…" (EX 1).

In a supplemental report dated August 5, 2004, Dr. Repsher reviewed additional medical and other records of the miner at the request of the employer. Among other things, he reviewed the miner's medical records from Terre Haute Regional Hospital and Union Hospital dating from November 1995 to January 2004 and a medical report from Dr. Robert Cohen dated March 12, 2004. After reviewing this extensive evidence, Dr. Repsher continued to opine that there was no radiographic evidence to support a diagnosis of coal workers' pneumoconiosis. The progressive decline in the miner's lung function, in Dr. Repsher's opinion, was due to recurrent bouts of bronchitis and pneumonia. According to Dr. Repsher:

> It has been proposed that even in the absence of exacerbation, bacterial colonization leafs to progressive airways destruction through a vicious cycle of infection, inflammation, injury, and further infection. Progressive airway obstruction ensues, aggravated by recurrent bouts of bronchitis with new strains of respiratory pathogens that are new to the patient. This is well described in the Journal of Respiratory Disease 2003; 24(6): 257-263.

(EX 3).

Dr. Repsher also testified by deposition on October 21, 2004. At his deposition, Dr. Repsher further reiterated his opinion provided in his medical report. (EX 7). In addition, Dr. Repsher testified that during his examination of the miner, he took a chest x-ray and high resolution CT scan of the miner's chest. According to Dr. Repsher, having both a CT scan and an x-ray is a "definite advantage" when determining the existence of pneumoconiosis.

Furthermore, Dr. Repsher noted that the miner showed signs and symptoms of congestive heart failure, which can cause apparent restrictive impairment. When asked why he believed that the miner's COPD was not related to coal mine dust, Dr. Repsher explained that COPD related solely to coal mine dust exposure "would not be something the patient would notice, and it would not impair his ability to do his work or enjoy his leisure time." (EX 7). In contrast to Dr. Cohen's opinion, Dr. Repsher opined that there was no evidence of "physiologic" pneumoconiosis because the "published literature clearly shows that inhalation of coal mine dust….causes very mild airways obstruction." In the physician's opinion, the miner's "biggest problem" was his heart disease. He testified that the COPD may have contributed to his condition, but he did not know how severe the COPD was. (EX 7).

Dr. Repsher testified at a second deposition on August 22, 2006. (EX 14). At this deposition, Dr. Repsher noted that the miner had received a "considerable amount of medical care and treatment" since 2004. In addition to the medical records from the miner's hospital visits in 2004 and 2005, Dr. Repsher reviewed the miner's autopsy report performed November 28, 2005. He noted that Dr. Antonio listed the cause of death as adult respiratory distress syndrome (ARDS). According to Dr. Repsher, ARDS is a clinical syndrome that occurs in people who are seriously ill from a variety of different causes, most commonly trauma and infection. In the miner's case, Dr. Repsher opined that his illness was due to infection.

Dr. Repsher also noted that Dr. Antonio indicated there was anthracosis on the miner's pleural surface. According to Dr. Repsher, this is not a diagnosis of coal workers' pneumoconiosis. The pleural surface, he testified, is the very thin covering of the lung. He further testified that anybody who has "done anything more than walk through a coal mine will have black appearing lungs because the pleura is black because it's been carrying coal dust away from the lung, but that is not black lung disease or coal workers pneumoconiosis." (EX 14).

This physician also testified that the miner showed no symptoms of clinical pneumoconiosis, based on the chest x-rays, medical history, and autopsy report. He also stated that the miner also showed no evidence of legal pneumoconiosis, which in the miner's case would be COPD or emphysema due to coal dust inhalation. According to Dr. Repsher, the autopsy is the "gold standard for diagnosing COPD and emphysema" in someone who is deceased. There was no evidence in the autopsy of COPD or emphysema. Dr. Repsher did state that the miner was totally disabled due to his "shortness of breath." However, according to the physician, "by far the most common cause of shortness of breath in the United States and other developed countries probably by a factor of 20 to one is heart disease…" (EX 14).

Dr. Repsher next addressed the opinion of Dr. Cohen, who stated that there was evidence by pulmonary function study of January 20, 2004 of coal workers' pneumoconiosis. According to Dr. Repsher, Dr. Cohen based this diagnosis on a pulmonary function test that was invalid due to the fact that the miner was suffering from congestive heart failure. Dr. Repsher also reviewed the November 3, 2005 pulmonary function test performed by Dr. Dultz. According to Dr. Repsher, these pulmonary function values were invalid primarily because the miner was suffering from severe end state congestive heart failure and his lungs had a massive infection and extra fluid preventing efficient oxygenation.

At the request of the employer, Dr. Joseph J. Renn performed an independent medical review of the miner's file and completed a report dated September 12, 2004. (EX 4). Dr. Renn reviewed the miner's medical records from Union Hospital, the January 20, 2004 medical report of Dr. Cohen, the March 24, 2004 report of Dr. Repsher, electrocardiographs dated from 2000 to 2004, pulmonary function tests from 2002 through 2004, and arterial blood gas tests taken in 2004. He also reviewed chest radiograph interpretations from 2002 through 2004 and the independent CT review by Dr. Wiot dated March 8, 2004. After reviewing all of the evidence, Dr. Renn opined that the miner suffered from chronic bronchitis with obstruction. He attributed this defect to several etiologies, but he found no convincing evidence of pneumoconiosis. He noted that the miner's chronic bronchitis resulted from years of tobacco smoking rather than exposure to coal mine dust. According to Dr. Renn, the miner had significant carbon dioxide retention which does not occur in coal workers' pneumoconiosis. He also noted that the miner had left pleural thickening and calcification, which does not occur in coal workers' pneumoconiosis. (EX 4).

On October 21, 2004, Dr. Renn testified by deposition. (EX 8). At his deposition, he elaborated upon the opinion provided in his medical report. He continued to opine that the miner did not suffer from coal workers' pneumoconiosis. In addition to the reasons stated in his medical report, Dr. Renn also testified that he based his opinion on the lack of physical findings associated with some individuals who have coal workers' pneumoconiosis. According to Dr. Renn, the miner did not have the physiologic pattern on his ventilatory function studies that are associated with coal workers' pneumoconiosis. Specifically, the physician noted that the miner did not have the "bibasilar lat inspiratory crackles" associated with pneumoconiosis. Instead, the miner showed inspiratory wheezes, diminished breath sounds, and diffuse rhonchi. Dr. Renn testified that the miner had "everything but the findings you associate with simple coal workers' pneumoconiosis." Reviewing the individual test results, Dr. Renn noted that the pulmonary function tests performed by Dr. Cohen on January 20, 2004 were not valid due to poor effort by the miner and congestive heart failure. He testified that the miner's severe heart disease caused a decreased fluid in the lungs which caused the restriction and obstruction. According to Dr. Renn, the pattern on the lung volume tests and pulmonary function tests showed a tobacco related disease. (EX 8).

Dr. Renn was deposed a second time on August 31, 2006, after having the opportunity to review the miner's most recent medical records and autopsy report. (EX 15). Based on his review of these records, Dr. Renn continued to opine that the miner did not suffer from coal workers' pneumoconiosis. He notes that Dr. Dultz relied on invalid pulmonary function studies in forming his opinion that the miner suffered from pneumoconiosis. (EX 15).

In connection with the miner's 1997 request for modification, six medical reports were submitted from Drs. Lenyo, Cohen, Selby, Tuteur, Repsher, and Renn. Of these physicians, only Drs. Lenyo and Cohen opined that the miner suffered from pneumoconiosis. A detailed summary of these medical opinions can be found in the previous administrative law judge decision dated January 11, 2002. (DX 74).

CT Scans

Dr. Jerome Wiot, a board-certified radiologist, reviewed a CT scan of the miner dated March 8, 2004. He noted that the scan showed extensive pleural disease on the left lung with calcification, most likely due to the miner's coronary by-pass surgery. According to the physician, pleural disease is not a manifestation of coal dust exposure. Dr. Wiot found no evidence of coal worker's pneumoconiosis.

Dr. Wiot also reviewed a CT scan dated October 26, 2005 from Union Hospital. He found no evidence of pneumoconiosis in the scan. (EX 9). Dr. Harold Spitz, another board-certified radiologist, reviewed this same CT scan and he also found no evidence of coal workers' pneumoconiosis. (EX 10).

Death Certificate

The miner's death certificate was signed by Dr. Vincent Puccia on December 6, 2005. The cause of death is listed as perforation of sigmoid colon, due to or as a consequence of respiratory failure. (DX 98).

Autopsy Report

The miner's autopsy was performed December 1, 2005. (DX 96). The pathologist is listed as Dr. Antoneitta Antonio. This physician noted that the miner was a 73-year-old male who was admitted to the hospital on November 19, 2005 due to severe abdominal pain/ruptured viscus. The pathology report showed perforated diverticulitis with bascess and periotonitis. The physician noted that the miner had a history of "CABG, artrial fibrillation, MI, pulmonary hypertension, CVA, and severe COPD/black lung with severe respiratory failure. (DX 96). Dr. Antonio noted that the pulmonologist assessment was respiratory failure secondary to COPD, and ARDS. The miner expired on November 26, 2005.

Before performing the autopsy, Dr. Antonio stated that it was to be limited to the miner's lungs. She found a black pigment on the pleural surface which she stated "could be anthracosis." No obvious black pigment was seen in both the right and left lung parenchyma. In summary, Dr. Antonio stated that the autopsy findings in the lungs show diffuse alveolar damage in both lobes of the lung. Massive pleural adhesions were also present in both lobes of the lung. The pathologist opined that, "there is no black lung identified in the lung." The cause of death was listed as adult respiratory distress syndrome. (DX 96).

Other Evidence

A digital x-ray interpretation dated January 1, 2004 was also offered into evidence.[4] This x-ray was interpreted by Dr. R.A. Cohen, who is a B-reader. He found no evidence of pneumoconiosis.

[4] In *Webber v. Peabody Coal Co*, 23 B.L.R. 1-123 (2006)(en banc) (J. Boggs, concurring), the Board adopted the Director's position and held that digital x-ray interpretations are not considered "chest x-ray" evidence under 20

Discussion

This claim relates to a request for modification of an adverse decision on a "duplicate" claim filed on April 30, 1996. Because the claim at issue was filed after March 31, 1980, the regulations at 20 C.F.R. Part 718 apply. 20 C.F.R. § 718.2 (2005). Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations underwent extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920 *et seq*. (2000). These changes do not apply to this claim.

The Act defines "pneumoconiosis" as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. When evaluating interpretations of miners' chest x-rays, an administrative law judge may assign greater evidentiary weight to readings of physicians with superior qualifications. 20 C.F.R. § 718.202(a)(1); *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211, 1-213 (1985).[5]

The record in the current request for modification contains four negative interpretations of one chest x-ray. In addition, a digital x-ray read by Dr. Cohen was also interpreted as negative for the disease. None of the most recent x-rays was read as positive for pneumoconiosis. In the miner's 1997 request for modification, thirty-three chest x-rays were submitted and the majority of these was read as negative. The negative readings constitute the majority of the x-ray interpretations; therefore, I find that the x-ray evidence does not prove pneumoconiosis.

C.F.R. §§ 718.101(b), 718.102, 718.202(a)(1), and Appendix A to Part 718 as they do not satisfy the quality standards at Appendix A. As a result, the Board held that digital chest x-rays are "properly considered under 20 C.F.R. § 718.107, where the Administrative Law Judge must determine, on a case-by-case basis, pursuant to 20 C.F.R. § 718.107(b), whether the proponent of the digital x-ray evidence has established that it is medically acceptable and relevant to entitlement." *See also Harris v. Old Ben Coal Co.*, 23 B.L.R. 1-__, BRB No. 04-0812 BLA (June 29, 2007) (en banc on recon.) (J. McGranery and J. Hall, concurring and dissenting), *aff'g.*, 23 B.L.R. 1-98 (2006) (en banc).

[5] When evaluating interpretations of miners' chest x-rays, an administrative law judge may assign greater evidentiary weight to readings of physicians with superior qualifications. 20 C.F.R. § 718.202(a)(1); *Roberts v. Bethlehem Mines Corp.*, 8 BLR 1-211, 1-213 (1985). Greater weight may be accorded the x-ray interpretation of a dually-qualified (B-reader and board-certified) physician over that of a board-certified radiologist. *Herald v. Director, OWCP*, BRB No. 94-2354 BLA (Mar. 23, 1995)(unpublished). The Board has held that it is also proper to credit the interpretation of a dually qualified physician over the interpretation of a B-reader. *Zeigler Coal Co. v. Director, OWCP [Hawker]*, 326 F.3d 894 (7th Cir. 2003) (complicated pneumoconiosis); *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). *See also Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985) (weighing evidence under Part 718).

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy or autopsy evidence. Section 718.106 sets forth the quality standards for autopsies. The Board had held that deference to autopsy evidence over x-ray evidence is reasonable because "autopsy evidence is the most reliable evidence of the existence of pneumoconiosis." *Terlip v. Director, OWCP*, 8 B.L.R. 1-363 (1985); *Energy West Mining Co. v. Director, OWCP [Jones]*, Case No. 03-9575 (10th Cir. July 9, 2004) (unpub.). The prosector may observe black pigment or anthracotic pigment in the lungs on autopsy. This pigment is generally the result of coal deposits embedded in the miner's lungs. In order for a diagnosis to qualify as "pneumoconiosis," there must be evidence that the lung tissue has reacted to the embedded coal deposits. Consequently, black pigment in the lungs, standing alone, does not constitute a finding of pneumoconiosis. On the other hand, observations of black pigment *with associated fibrosis* would qualify as a diagnosis of the disease. *Hapney v. Peabody Coal Co.*, 22 B.L.R. 1-106 (2001) (en banc).

I lend great weight to the results of the autopsy report. Although Dr. Antonio mentioned she found evidence of a black pigment in the miner's lungs which "could be anthracosis," this standing alone does not constitute a diagnosis of pneumoconiosis. In fact, Dr. Antonio stated that she found no evidence of black lung in the miner's lungs, although it was reported that the miner had a history of the disease. This report is supported by the most recent chest x-ray evidence which also did not support the existence of the disease. Therefore, I find that the claimant has failed to establish the existence of pneumoconiosis through autopsy evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions applies to this claim, claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides the fourth and final way for a claimant to prove that he has pneumoconiosis. Under this section, a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis.

A "documented" medical opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields, supra.*

An unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). *See also Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986) (a report which is internally inconsistent and inadequately reasoned may be

entitled to little probative value). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d 982 (8th Cir. 1985)*; Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.*, 4 B.L.R. 1-601 (1982). Although a report cannot be discredited simply because a physician did not consider all medical data of record, it is proper to accord greater weight to an opinion which is better supported by the objective medical data of record, *i.e.*, x-ray, blood gas, and ventilatory studies. *Minnich v. Pagnotti Enterprises, Inc*., 9 B.L.R. 1-89, 1-90 n. 1 (1986); *Wetzel v. Director, OWCP*, 8 B.L.R. 1-139 (1985).

Furthermore, a physician's report may be rejected where the basis for the physician's opinion cannot be determined. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182 (1984). Similarly, a report which is seriously flawed may be discredited. *Goss v. Eastern Assoc. Coal Corp.*, 7 B.L.R. 1-400 (1984). As an example, an administrative law judge properly discredited a physician's opinion as undocumented where it was based only upon the claimant's work history, subjective complaints, and an unreliable blood gas study. *Mahan v. Kerr-McGee*, 7 B.L.R. 1-159 (1984).

More weight may be accorded to the conclusions of a treating physician as he or she is more likely to be familiar with the miner's condition than a physician who examines him episodically. *Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989). However, an administrative law judge "is not required to accord greater weight to the opinion of a physician based solely on his status as claimant's treating physician. Rather, this is one factor which may be taken into consideration…" *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103 (1994). Other factors to be considered include whether the report is well-reasoned and well-documented. *Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992) (a treating physician's report which is not well-reasoned or well-documented should not be given greater weight). Similarly, in *Lango v. Director, OWCP*, 104 F.3d 573 (3rd Cir. 1997), the court held that a treating physician's opinion may be accorded greater weight than the opinions of other physicians of record but "the ALJ may permissibly require the treating physician to provide more than a conclusory statement before finding that pneumoconiosis contributed to the miner's death."

In the most recent claim and request for modification, five medical reports were submitted into evidence. Drs. Renn and Repsher found no evidence of clinical or legal pneumoconiosis, in accord with the results of the autopsy. As Dr. Repsher testified, the autopsy is the "gold standard" in determining the existence of pneumoconiosis in someone who is deceased. Although the miner's extensive medical records are replete with references to "black lung disease," Dr. Repsher notes that no objective evidence is ever offered to confirm this diagnosis. The diagnoses of black lung disease in the miner's treatment records are usually "by history" with no explanation as to how the diagnosis was reached.

Although the miner consistently complained of shortness of breath and other respiratory illnesses during his numerous hospitalizations, Dr. Repsher notes these symptoms can easily be attributed to the miner's congestive heart failure. In fact, according to Dr. Repsher, congestive heart failure is the underlying cause of the overwhelming majority of respiratory problems in the

United States. Furthermore, Dr. Renn notes that the miner's medical records did not support a physical finding of clinical or legal pneumoconiosis. The miner showed evidence of wheezes, diminished breath sounds, and rhonchi, which Dr. Renn noted are not findings one would normally associate with coal workers' pneumoconiosis.

Drs. Dultz and Mardini both disagree with Drs. Renn and Repsher. These physicians found that the miner suffered from pneumoconiosis. However, I find their opinions to be unreasoned. Dr. Dultz treated the miner while he was hospitalized for a fractured leg and he stated that the miner was diagnosed with black lung disease but "the details were lacking." Dr. Dultz then goes on to state that a CT scan of the miner showed asbestos exposure and ground glass opacities. It is unclear how these results support Dr. Dultz's opinion. As Dr. Renn notes, asbestos exposure and ground glass opacities are not indicative of coal workers' pneumoconiosis. Furthermore, this CT scan was re-read by two board-certified radiologists, Drs. Wiot and Spitz. Neither of these specialists found any evidence of pneumoconiosis in the CT scan.

Dr. Dultz stated that he primarily based his opinion on the miner's November 5, 2005 pulmonary function study, radiographic findings, and work history. It is unclear to which radiographic findings he is referring. No radiographic findings submitted in the miner's most recent request for modification showed any indication of pneumoconiosis. Moreover, the November 5, 2005 pulmonary function test was taken while the miner was hospitalized for various illnesses, including congestive heart failure. Drs. Renn and Repsher both opined that these studies were unreliable due to the miner's decreased lung state as a result of his congestive heart failure.

Dr. Mardini also provided a brief letter diagnosing coal workers' pneumoconiosis. Dr. Mardini was the miner's treating physician and ordinarily his opinion would be attributed greater weight. However, Dr. Mardini provides no support or objective medical evidence in support of his opinion. He merely states that "multiple chest x-rays and pulmonary function tests" support his diagnosis of pneumoconiosis. However, as mentioned previously, no chest x-rays submitted into the record were read as positive for the disease and two experts in pulmonary disease have opined that the pulmonary function studies in the miner's medical records are unreliable due to the miner's congestive heart failure.

The only physician to provide a well-documented opinion that the miner suffered from pneumoconiosis is Dr. Cohen. This physician is board-certified in internal medical and pulmonary disease and he had the opportunity to examine the miner and reached a conclusion based on the results of his examination. He performed a pulmonary function test, arterial blood gas study, and chest x-ray upon the miner. He opined that the miner showed physiologic evidence of pneumoconiosis based on his pulmonary function test. Given the fact that the miner worked eighteen plus years in coal mine employment and he showed symptoms of COPD, it was not unreasonable for Dr. Cohen to reach this conclusion. However, Dr. Cohen did not have the opportunity to examine the miner's autopsy report in which the pathologist found no evidence of the pneumoconiosis. In addition, he based his opinion on a pulmonary function test which two pulmonary experts later found to be invalid. Therefore, although I find his opinion to be well-

reasoned, it is outweighed by the opinion of Dr. Antonio in the autopsy report and the supporting opinions of Drs. Repsher and Renn.

The opinions of Drs. Repsher and Renn are in congruence with the older medical opinion evidence. The majority of the physicians found, in conjunction with the claim filed in 1997, that there is no evidence of pneumoconiosis. I agree with the previous administrative law judge that the older evidence does not support a finding of the disease.

After considering all the newly submitted medical opinions in conjunction with the older evidence, I resolve the conflict of opinions by according greater probative weight to the opinion of Dr. Antonio in the autopsy report. I also lend great weight to the opinions of Drs. Repsher, and Renn. Both of these physicians possess excellent credentials in the field of pulmonary disease. I also find their reasoning and explanation in support of their conclusions more complete and thorough than that provided by the physicians who concluded that the miner suffered from pneumoconiosis. I also find the opinions of these physicians to be in better accord both with the evidence underlying their opinions and the overall weight of the medical evidence of record. Therefore, the claimant has not established that the miner suffered from pneumoconiosis per Section 718.202(a)(4).

The previous administrative law judge determined that the miner was totally disabled, and each physician in the miner's most recent request for modification also opined that the miner was totally disabled. Therefore, the only issue left to be decided is whether the miner's disability was due to pneumoconiosis. As I have found that the miner does not suffer from pneumoconiosis, the issue of whether or not his disability was due to pneumoconiosis is moot.

In conclusion, the newly submitted evidence, when considered in conjunction with the evidence in the prior claims, continues to establish that claimant was totally disabled but fails to establish that he suffered from pneumoconiosis. I find there has been no mistake in a determination of fact or change in conditions of entitlement. Accordingly, the claimant's request for modification must be denied.

ORDER

IT IS HEREBY ORDERED that the request for modification dated October 10, 2003 is hereby denied.

A

DONALD W. MOSSER
Administrative Law Judge

Notice of Appeal Rights: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with Board within thirty (30) days from the date of which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* C.F.R §802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).